



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SIERRA MEDICAL CENTER
C/O LAW OFFICE OF P MATTHEW ONEILL
6514 MCNEIL DR BLDG 2 STE 201
AUSTIN TX 78729

Respondent Name

EL PASO ISD

Carrier's Austin Representative Box

Box Number 42

MFDR Tracking Number

M4-99-0784-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position statement for consideration in this dispute.

Amount in Dispute: \$6,330.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Attached is the documentation to support our position. Please note that the length of stay was not pre-authorized. The treatment may not have been originally submitted under workers compensation."

Response Submitted by: Lindsey Morden Claim Services, Inc. 4141 Pinnacle Street, Los Arcos Building Suite 101, El Paso, Texas 79902

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
September 23, 1997 to September 23, 1997	Inpatient Hospital Services	\$6,330.20	\$1,361.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the procedures for resolving medical fee disputes.
2. Former 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 *TexReg* 6264, sets out the fee

guidelines for acute care inpatient hospital services.

3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on July 21, 1998.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - F – Reduction According to Acute Care Inpatient Hospital Fee Guideline. (Prospective Payment System/Per Diem.)
 - M – Reduced to Fair & Reasonable

Findings

1. The respondent's position statement asserts that "Please note that the length of stay was not pre-authorized." Former Texas Labor Code §408.027(d) [currently 408.027(e)], Acts 1993, 73rd Legislature, chapter 269, effective September 1, 1993, requires that "If an insurance carrier disputes the amount of payment or the health care provider's entitlement to payment, the insurance carrier shall send to the commission [now the Division], the health care provider, and the injured employee a report that sufficiently explains the reasons for the reduction or denial of payment for health care services provided to the employee." Review of the submitted explanations of benefits finds no notation of payment exception code "A" or other payment exception code indicating that services were denied or reduced for no preauthorization. No documentation was found to support that the insurance carrier sent the required report containing sufficient explanation of the above reason(s) for the reduction or denial of payment to the commission [now the Division], the health care provider, and the injured employee. The Division concludes that the respondent has not met the requirements of §408.027. This denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
2. This dispute relates to inpatient services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.401, effective August 1, 1997, 22 TexReg 6264. Review of the submitted documentation finds that the length of stay was 3 days. The type of admission is surgical; therefore, the standard surgical per diem amount of \$1,118.00 multiplied by the length of stay of 3 days yields a reimbursement amount of \$3,354.00. This amount less the amount paid by the insurance carrier of \$1,993.00 leaves an amount due to the requestor of \$1,361.00. This amount is recommended.
3. Additionally, per Texas Administrative Code §134.401(c)(4)(B)(i), requires that, when medically necessary, Magnetic Resonance Imaging (MRIs) (revenue codes 610-619), shall be reimbursed at a fair and reasonable rate. Review of the medical bill finds that the requestor is disputing payment of a MRI (revenue code 610).
4. 28 Texas Administrative Code §134.1(f), effective October 7, 1991, 16 *Texas Register* 5210, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, sec. 8.21(b), until such period that specific fee guidelines are established by the commission."
5. The former Texas Workers' Compensation Act section 8.21 was repealed, effective September 1, 1993 by Acts 1993, 73rd Legislature, chapter 269, section 5(2). Therefore, for services rendered on or after September 1, 1993, the applicable statute is the former version of Texas Labor Code section 413.011(b), Acts 1993, 73rd Legislature, chapter 269, section 1, effective September 1, 1993, which states, in pertinent part, that "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle."
6. Review of the submitted documentation finds that:
 - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated for the MRI.
 - The requestor does not discuss or explain how payment of the amount sought would result in a fair and reasonable reimbursement for the MRI services in this dispute.
 - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement for the disputed MRI services.
 - The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement for the MRI services is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the MRI services in dispute. Additional payment for the MRI services is not recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that additional reimbursement is due. As a result, the amount ordered is \$1,361.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$1,361.00 plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature

_____	<u>Grayson Richardson</u>	<u>December 16, 2011</u>
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.